

NEUROPSYCHOLOGY SERVICE
ADULT Background Questionnaire: Adult

Please complete and bring to appointment. This form is confidential once completed.

The following is a detailed questionnaire on the development, medical history, and current functioning of a person who is assessed by OSU Behavioral Medicine Clinic. This information will be integrated with the testing results in order to provide a better picture of our client's abilities. Please fill out this questionnaire as completely as you can.

Person filing out this form: _____ Relationship to the client: _____

BACKGROUND and FAMILY

Name: _____ Today's Date: _____

Birthdate: _____ Age: _____ Grade (if applicable): _____ Name of School: _____

Occupation (if applicable): _____

Highest Grade Completed: _____ Area of Vocational Training: _____

Birth Country: _____ Age on arrival in the US if born elsewhere: _____

Biological Mother's Name: _____ Age: _____ Highest Grade Completed: _____

_____ Degree/Diploma (if applicable): _____ Occupation: _____

Biological Father's Name: _____ Age: _____ Highest Grade Completed: _____

_____ Degree/Diploma (if applicable): _____ Occupation: _____

Marital status: _____

Spouse/Partner Name: _____ Age: _____ Highest Grade Completed: _____

_____ Degree/Diploma (if applicable): _____ Occupation: _____

Do you have children or other dependent? ☐ Yes ☐ No

If Yes, list all children/dependent:

Name	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If separated or divorced:

When the separation occurred? _____

Who has a legal custody of children (if applicable)? _____

If your children are not living with either biological parent (if applicable):

Reason: _____

Name(s) of legal guardian(s): _____

List all people currently living in your household:

Name	Relationship to You	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 If any of your children are living outside the home, please list their names and ages:

Primary language spoken in the home: _____

Other languages spoken in the home: _____

If your first language is not English, please complete the following:

Your first language: _____

Age at which you learned English: _____

HAND USE

Please indicate which hand (or foot) you use for:

Writing: Right Left Both (Equal)

Throwing a ball: Right Left Both (Equal)

Kicking a ball: Right Left Both (Equal)

Using Scissors: Right Left Both (Equal)

****Is there anyone in your family who is left-handed? If yes, please list relationship to you:**

YOUR DEVELOPMENTAL HISTORY

If you are adopted, please fill in as much of the following information as you are aware of.

During pregnancy, did your biological mother:

	Yes/No	If Yes, list name and frequency:	List the duration	Other
Take any medication?				
Smoke?				
Drink alcohol?				
Use Drugs?				

List any complications during pregnancy (excessive vomiting, excessive staining/blood loss, threatened miscarriage, infections, toxemia, fainting, dizziness, etc.): _____

Duration of pregnancy (weeks): _____

Duration of labor (hours): _____ APGAR (0-10): _____ (1min) / _____ (5min)

Were there any complications? Yes/No If yes, please explain:

Were any indications of fetal distress? Yes/No If yes, please explain:

Circle any that apply to the birth: Jaundice Breathing Problems Incubator Birth Defect Other:

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What was your birth weight? _____

Duration of stay in hospital as an infant? _____

Were any of the following present during your infancy or the first few years of life?

- | | |
|---|--|
| ☐ Speech delay | ☐ Colic |
| ☐ Motor delay | ☐ Excessive restlessness |
| ☐ Cognitive delay | ☐ Excessive sleep |
| ☐ Unusually quiet or inactive | ☐ Diminished sleep |
| ☐ Did not like to be held or cuddled | ☐ Constantly into everything |
| ☐ Not alert | ☐ Excessive number of accidents |
| ☐ Difficult to soothe | |

Please indicate the approximate age at which you first showed the following behaviors by checking the appropriate box. Check "Never" if you have never shown the listed behavior.

	Early	Average	Late	Never	Comments
Smiled	☐	☐	☐	☐	_____
Rolled over	☐	☐	☐	☐	_____
Sat alone	☐	☐	☐	☐	_____
Crawled	☐	☐	☐	☐	_____
Walked	☐	☐	☐	☐	_____
Ran	☐	☐	☐	☐	_____
Babbled	☐	☐	☐	☐	_____
First word	☐	☐	☐	☐	_____
Sentences	☐	☐	☐	☐	_____
Tied shoelaces	☐	☐	☐	☐	_____
Dressed self	☐	☐	☐	☐	_____
Fed self	☐	☐	☐	☐	_____
Bladder trained, day	☐	☐	☐	☐	_____
Bladder trained, night	☐	☐	☐	☐	_____
Bowel trained	☐	☐	☐	☐	_____
Rode tricycle	☐	☐	☐	☐	_____
Rode bicycle	☐	☐	☐	☐	_____

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SEIZURES (IF APPLICABLE)

Indicate approximate date/age when your seizures started: _____

Indicate approximate date of last seizure: _____

Seizures Occur (Circle one):

☐ Daily (____per day) ☐ Weekly (____per week) ☐ Monthly (____per month) ☐ Other: _____

Over the last year, seizures have become:

- ☐ More frequent
☐ Less frequent
☐ About the same

MEDICAL HISTORY

	Yes/No	If Yes, Describe:	Date of last examination:
Vision Problems	_____	_____	_____
Hearing Problems	_____	_____	_____

Place a check mark next to any illness or condition that you had. When you check an item, also note the approximate date of the illness (if you prefer, you can simply indicate your age at illness).

Illness or condition	Date(s) or age(s)	Illness or condition	Date(s) or age(s)
☐ Measles	_____	☐ Poisoning	_____
☐ Mumps	_____	☐ Severe Headaches	_____
☐ Chicken Pox	_____	☐ Rheumatic Fever	_____
☐ Whooping cough	_____	☐ Tuberculosis	_____
☐ Diphtheria	_____	☐ Bone or Joint Disease	_____
☐ Meningitis	_____	☐ STD	_____
☐ Scarlet Fever	_____	☐ Blood Disorders	_____
☐ Encephalitis	_____	☐ Jaundice	_____
☐ High Fever	_____	☐ Diabetes	_____
☐ Seizures	_____	☐ Cancer	_____
☐ Injuries to the Head*	_____	☐ High Blood Pressure	_____
☐ Loss of Consciousness	_____	☐ Heart Disease	_____
☐ Broken Bones	_____	☐ Asthma	_____
☐ Hospitalizations /ED visits	_____	☐ Physical Abuse	_____
☐ Surgeries	_____	☐ Sexual Abuse	_____
☐ Ear Infections	_____	☐ Other	_____

*if ✓, please complete head injury history form

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CURRENT MEDICATIONS

Medication	Reason Taken	Dosage	Start Date	Taken at the time of injury (if applicable)?

TREATMENT/ASSESSMENT HISTORY

List any previous treatment or assessments that you had:

Type (OT, PT, Psychology)	Reason	Dates of Testing	Name of Examiner/Location

Have there been any recent stressors that you think may be contributing to your difficulties?

FAMILY MEDICAL HISTORY

Place a check any illness or condition that any member of your immediate or extended family has had.

Condition	Relationship to you	Condition	Relationship to you
☐ Seizures or Epilepsy		☐ Tics/Tourette's syndrome	
☐ Attention deficit		☐ Alcohol abuse	
☐ Hyperactivity		☐ Drug abuse	
☐ Learning disabilities		☐ Suicide attempt	
☐ Intellectual disability		☐ Antisocial behavior	
☐ Childhood behavior problems		☐ Physical abuse	
☐ Mental illness		☐ Sexual abuse	
☐ Depression		☐ Neurological illness	
☐ Anxiety		or disease	

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EDUCATION HISTORY

Please estimate your current academic abilities or your academic abilities in the last year of your formal schooling:

	Far Below Grade	Somewhat Below Grade	At Grade Level	Somewhat Above Grade	Far Above Grade
Language Arts:	☐	☐	☐	☐	☐
Math:	☐	☐	☐	☐	☐
Science:	☐	☐	☐	☐	☐
Social Studies:	☐	☐	☐	☐	☐
Other (_____)	☐	☐	☐	☐	☐

Attention

	Yes	No	If Yes, please describe when/what?
Have you ever had trouble paying attention at school, work or home?	☐	☐	_____
Have you ever been diagnosed with an attention disorder?	☐	☐	_____
Have you ever received treatment of attention disorder?	☐	☐	_____

Learning

Have you ever had trouble learning? ☐Yes ☐No

Have you ever been diagnosed in a learning disorder? ☐Yes ☐No

If yes, when: _____

Have you ever received learning assistance at school? ☐Yes ☐No

If yes, please describe: _____

Have you ever received tutoring ☐Yes ☐No

If yes, please describe: _____

Academic Accommodations/Individual Program or Education Plan

Have you ever had a modified learning program? ☐Yes ☐No

Was there an individual educational plan/504 ☐Yes ☐No

If yes, when was it created/implemented? _____

Have you ever been formally recognized with Educational Coding? ☐Yes ☐No

If yes, indicate code: _____

Have you ever been in special education classes? ☐Yes ☐No

If yes, please describe: _____

Have you ever been held back a grade? ☐Yes ☐No

If yes, indicate grade and year: _____

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Classroom Behaviors

Have you ever been *suspended* from school? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever been *expelled* from school? ☐ Yes ☐ No

If yes, please describe: _____

Briefly describe classroom or school problems if applicable: _____

OTHER INFORMATION

Have you ever been in trouble with the law? ☐ Yes ☐ No

If yes, please describe: _____

Have you ever committed any acts of abuse (physical/sexual/other) against someone else? _____

What are your strengths? _____

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BEHAVIOUR CHECKLIST (CURRENT FUNCTIONING)

Place a check mark next to behaviors that you believe you currently exhibit at this time.

Sleeping and Eating

- ☐ Nightmares
- ☐ Trouble sleeping
- ☐ Eats poorly
- ☐ Eats excessively

Social Development

- ☐ Prefers to be alone
- ☐ Excessively shy or timid
- ☐ More interested in objects than in people
- ☐ Difficulty making friends
- ☐ Teased by others
- ☐ Bullied other children
- ☐ Lacks of friends
- ☐ Difficulty seeing another person's point of view
- ☐ Doesn't empathize with others
- ☐ Overly trusting of others
- ☐ Doesn't appreciate humor

Behavior/Psychosocial

- ☐ Stubborn
- ☐ Irritable, angry, or resentful
- ☐ Frequent tantrums
- ☐ Strikes out at others
- ☐ Throws or destroys things
- ☐ Lying
- ☐ Stealing
- ☐ Argues with others
- ☐ Low frustration threshold
- ☐ Daredevil behavior
- ☐ Runs away
- ☐ Needs a lot of work supervision

- ☐ Impulsive (does things without thinking)
- ☐ Poor sense of danger
- ☐ Dangerous to self or others (describe):

- ☐ Purposely harms or injures self (describe):

- ☐ Thinks of suicide (describe):

- ☐ Performs acts of self-harm (describe):

- ☐ Unusual fears, habits or mannerisms (describe):

- ☐ Feels depressed
- ☐ Cries frequently
- ☐ Excessively worried and anxious
- ☐ Overly preoccupied with details
- ☐ Overly attached to certain objects
- ☐ Not affected by negative consequences
- ☐ Drug abuse
- ☐ Alcohol abuse

Other Problems

- ☐ Poor bowel control (soils self)
- ☐ Bladder control problems (not during a seizure)
- ☐ Overreacts to noises
- ☐ Overreacts to touch
- ☐ Excessive daydreaming and fantasy life
- ☐ Motor/Vocal tics

Motor Skills

- ☐ Poor gross motor coordination
- ☐ Poor fine motor coordination

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COGNITIVE CHECKLIST (CURRENT FUNCTIONING)Rate your *current* cognitive skills relative to other people of the same age.

	Above Average	Average	Below Average	Severe Problem
Speech	☐	☐	☐	☐
Comprehension of speech	☐	☐	☐	☐
Problem solving	☐	☐	☐	☐
Attention span	☐	☐	☐	☐
Organizational skills	☐	☐	☐	☐
Remembering events	☐	☐	☐	☐
Remembering facts	☐	☐	☐	☐
Learning from experience	☐	☐	☐	☐
Understanding concepts	☐	☐	☐	☐
Overall Intelligence	☐	☐	☐	☐

Check any specific problems that are currently present:

- | | |
|---|--|
| ☐ Poor articulation | ☐ Easily distracted |
| ☐ Difficulty finding words to express self | ☐ Frequently forgets instructions |
| ☐ Disorganized speech | ☐ Frequently loses belongings |
| ☐ Ungrammatical speech | ☐ Difficulty planning tasks |
| ☐ Talks like a child | ☐ Doesn't foresee consequences of actions |
| ☐ Slow learner | ☐ Slow thinking |
| ☐ Forgets to do things | |

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PLEASE COMPLETE THIS PAGE ONLY IF YOU HAVE HAD A RECENT INJURY OR A RECENT CHANGE

If a change has occurred, what is the cause and date of the change*? _____

**if the cause of the change is a concussion/traumatic brain injury, please complete the Head Injury History Form*

BEHAVIOUR CHECKLIST (PRIOR TO AN INJURY OR RECENT CHANGE)

**** Place a check mark next to behaviors that you believe you exhibited PRIOR to the injury or change.**

BEHAVIOUR CHECKLIST (PRIOR FUNCTIONING)

Place a check mark next to behaviors that you believe you exhibited PRIOR to the injury or change.

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